

MEDICAL RELEASE FORM
(CONFIDENTIAL)

I, _____, have retained Medical Financial Consulting
(Patient name)
and/or its designated representative (Lori Harris, RN) for review of services and charges
incurred by the patient at your facility.

MFC has the authority to review and/or have access to any and all medical/hospital bills,
insurance claim forms, and all medical records including treatment for communicable or
infectious disease, drug or alcohol abuse, HIV or mental health treatment.

MFC will interact with _____ for the purpose
(Name of facility)
of acquiring the necessary information, documentation, or to clarify questions that may
arise during the review.

Facility Address: _____

City: _____ State: _____ Zip Code: _____
(I agree that a photographic copy of this authorization will be as valid as the original.)

Patient Signature

Date

Insurance Company Name

Hospital Confinement Dates:

OR

Patient Authorized Representative:

Relationship

Explanation of why patient cannot sign:

The hospital requires that the patient must sign this authorization unless he/she is
deceased, a minor, judged mentally incompetent by a court of law or otherwise medically
unable to sign.

The authorized person means the parent, guardian or legal custodian of the minor patient,
the guardian or conservator of a patient judged incompetent, the spouse of a deceased
patient or a person designated in writing by the patient. In the case that a spouse does not
survive a deceased patient, a member of the deceased's immediate family may qualify.

Should you have any questions regarding this matter, please feel free to contact Lori
Harris, RN @ (269) 217-7829.